NEW HAMPSHIRE INSURANCE DEPARTMENT
21 SO. FRUIT STREET, STE 14
CONCORD NH 03301
Phone: 1-800-852-3416 or 1-603-271-2261
Fax: 1-603-271-0248

COMPLAINT FORM

The Consumer Division of the New Hampshire Insurance Department attempts to mediate disputes between consumers and their insurance companies or agents. The Department cannot act as your lawyer, give legal advice, recommend, or rate insurers. In order for us to assist you with your complaint, please complete this form as thoroughly as you can and return it to the address shown above. You will receive a written acknowledgement of your complaint from the Department. A copy of your complaint will be sent to the company or agent for their response. We will contact you when we receive the company's / agent's response. If we are unable to obtain the resolution you seek, you may wish to contact an attorney for advice on other remedies that may be available to you.

PLEASE TYPE OR PRINT CLEARLY

1. NAME OF COMPLAINANT

2. MAILING ADDRESS (STREET) (CITY) (ZIP CODE)

3. DAYTIME TELEPHONE NUMBER YOUR E-MAIL ADDRESS (optional)

4. NAME OF INSURED (IF SAME INDICATE SAME, IF OTHER THAN INSURED, SPECIFY)

5. WHO IS COMPLAINT AGAINST? (A COMPANY, AGENCY, BROKER, AGENT, PRODUCER, ADJUSTER OR OTHER - CIRCLE ONE)

NAME : _____

6. ADDRESS OF ABOVE (IF KNOWN) (STREET) (CITY) (ZIP CODE)

7. GROUP OR POLICY NUMBER DATE OF ISSUE

8. CLAIM NUMBER DATE OF LOSS

9. TYPE OF COVERAGE (CHECK ONE)

☐ AUTOMOBILE ☐ HOMEOWNERS ☐ COMMERCIAL ☐ LIABILITY ☐ LIFE ☐HEALTH ☐ DISABILITY INCOME

☐ DENTAL ☐ LONG TERM CARE ☐ ANNUITY ☐ MEDICARE SUPPLEMENT ☐ OTHER _____

10. REASON FOR COMPLAINT (CHECK ONE)

☐ CLAIM DELAY/DENIAL ☐ PREMIUM ☐ CANCELLATION ☐ OTHER (SPECIFY) _____

11. HAVE YOU ATTEMPTED TO RESOLVE THIS MATTER WITH THE COMPANY, AGENT, AGENCY OR OTHER INDIVIDUAL? ☐ YES ☐ NO DATE_____

PERSON YOU SPOKE WITH (IF KNOWN)_____**TELEPHONE NUMBER (**_____**)**_____

12. **PLEASE DESCRIBE YOUR PROBLEM IN DETAIL. ATTACH ADDITIONAL PAGES, IF NECESSARY. PLEASE INCLUDE COPIES (NOT ORIGINALS) OF IMPORTANT PAPERS, LETTERS, OR OTHER INFORMATION, THAT IS RELEVANT TO THIS MATTER.**

13. **WHAT WOULD YOU CONSIDER TO BE A FAIR RESOLUTION OF YOUR PROBLEM?**

INFORMATION REGARDING SELF-FUNDED EMPLOYER HEALTH BENEFIT PLANS:

Disputes involving self-funded employer benefit plans, come under the jurisdiction of the federal government. The following procedure must be followed for these types of plans: plan beneficiaries (participants) who have a dispute with a self-funded medical benefit plan, i.e., denial of benefits, have a right of appeal. The plan beneficiary must write a letter of appeal to the plan administrator. The name and address should be obtained from the plan document or human resource (benefit) department of the company. Plan beneficiaries have 60 days to appeal a denial and must receive a decision on the appeal within 60 days after that, unless the plan: (1) provides for a special hearing, or (2) specifies that the decision must be made by a group, which meets only on a periodic basis.

CONSENT TO RELEASE INFORMATION

The information I have provided is true and accurate to the best of my knowledge. This information may be forwarded to the insurance company and/or agent involved.

Signature: _____ **Date:** _____

I authorize the New Hampshire Insurance Department to share with the insurance company/provider named in this complaint any medical information/records I have provided in connection with this complaint. I further authorize the insurance company/provider to release medical information/records to the New Hampshire Insurance Department, if the information is relevant to this complaint. I understand that pursuant to New Hampshire's Right to Know law, RSA 91-A, information in this complaint file may become available for public inspection, but that any information that could identify me, or any person on whose behalf I have filed this complaint, including names, addresses, social security numbers or similar information, will be removed from the record prior to its release under New Hampshire RSA 91-A.

Signature: _____ **Date:** _____